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| **Transition Plan1** |
| Inmate Last Name: | First Name: | MI: | Gender M □ F □ |
| DOC Number: | SSN# | DOB: | Today’s Date: |
| Name of Facility: | Person Completing Form: |
| Current Status:  | Pretrial Detainee □ | Sentenced Inmate □ |
| Date of Admission: | Expected Release Date: |
| **Risk Level, Treatment, and Criminogenic Needs** |
| Was the inmate’s screen and assessment questionnaire reviewed? | Yes □ | No □ |
| Risk/Needs Assessment Score:  | High □ | Medium □ | Low □ |
| **Interventions Needed** |
| **Identification**  |
| Social Security Card | Yes □ | No □ | Veteran Identification Card | Yes □ | No □ |
| Birth Certificate | Yes □ | No □ | Passport | Yes □ | No □ |
| Alien Registration Card | Yes □ | No □ | Valid State ID/Driver’s License  | Yes □ | No □ |
| Picture Identification | Yes □ | No □ | Military Discharge Papers | Yes □ | No □ |
| Certificate of Naturalization | Yes □ | No □ | High School Diploma/GED Certificate | Yes □ | No □ |
| Are any identification documents in inmate’s property? |
| If yes, specify type of documentation: |
| If no, explain how identification is being obtained: |
| **Benefit Eligibility** |
| Public Assistance | Yes □ | No □ | Food Stamps | Yes □ | No □ |
| Medicaid | Yes □ | No □ | SSI | Yes □ | No □ |
| SSD | Yes □ | No □ | Veteran | Yes □ | No □ |
| **Transportation** |
| If known – Time of Release |
| Will someone pick up the inmate? | Yes □ | No □ |
| If yes, who? |
| If no, how will the inmate get home? |
| **Housing** |
| Address at Release: | Apt #: |
| City: | State: | Zip Code: |
| Home Phone: | Cell Phone: | Work Phone: |
| Residents in House: |
| Does the inmate expect to be released to known housing? | Yes □ | No □ |
| Does the inmate expect to be released to a homeless shelter? | Yes □ | No □ |
| Type of housing assistance required: |
| **Medical/Mental Health/Dental** |
| Primary health care needed: | Yes □ | No □ |
| Medical specialist needed: | Yes □ | No □ |
| Mental health provider needed: | Yes □ | No □ |
| Medication needed: | Yes □ | No □ |
| Date of last full physical: |
| **Substance Abuse Counseling/Treatment** |
| Alcohol counseling/treatment needed: | Yes □ | No □ |
| Substance abuse counseling/treatment needed: | Yes □ | No □ |
| Level of care required: | Outpatient □ | Residential □ |
| **Family** |
| Will have custody of children:  | Yes □ | No □ | If yes, how many?  | Ages: \_\_\_, \_\_\_, \_\_\_, \_\_\_, \_\_\_ |
| Family counseling needed: | Yes □ | No □ |  |
| **Education** |
| Has GED | Yes □ | No □ | Has H.S. diploma | Yes □ | No □ |
| Continuing education needed: | Yes □ | No □ |  |
| **Employment** |
| Job skills training needed: | Yes □ | No □ | Area of interest: |
| Job placement needed: | Yes □ | No □ | Special skills: |
| **Financial Obligations** |
| Court: | Child Support: | Medical: | Civil: |
| Other: | Other: |  |  |
| **In-Jail Program Participation** |
| Completion Information |  | Postrelease Referral |
| AA/NA | Yes □ | No □ | N/A □ | Yes □ |
| Anger Management | Yes □ | No □ | N/A □ | Yes □ |
| Cognitive Behavioral Change | Yes □ | No □ | N/A □ | Yes □ |
| Domestic Violence | Yes □ | No □ | N/A □ | Yes □ |
| Education | Yes □ | No □ | N/A □ | Yes □ |
| Employment Skills | Yes □ | No □ | N/A □ | Yes □ |
| Inmate Worker | Yes □ | No □ | N/A □ | Yes □ |
| Parenting | Yes □ | No □ | N/A □ | Yes □ |
| Religious Studies | Yes □ | No □ | N/A □ | Yes □ |
| Substance Abuse | Yes □ | No □ | N/A □ | Yes □ |
| Other: | Yes □ | No □ | N/A □ | Yes □ |
| Other: | Yes □ | No □ | N/A □ | Yes □ |
| **Post-Release Community Referrals**  |
| Check each need and then fill out a separate referral for each need.  |
| Aging & Disability Services □ | Community Corrections □ | Domestic Violence □ | Drug or Alcohol Treatment □ | Education □ |
| Employment □ | Coping Skills –Family/Children □ | Management of Financial Resources □ | Food/Clothing □ | Health CareBenefits □ |
| Housing □ | Identification □ | Income/Benefits/Entitlements □  | Life Skills Training  | Medical/Dental Care/Local Health Clinic □ |
| Mental Health Care □ | Medication Assistance □ | Rent Assistance □ | Social Security □ | Transportation □ |
| Unemployment □ |  Vocational Training □ |  |  |  |
|  |
| **1. Referral Type:** |
| In-Custody: □ | At Discharge: □ | Post-Release: □ |
| Agency Referred To: | Contact Phone: | Contact Person: |
| Appointment Date/Time: | Location: | Referral Faxed/E-mailed: Yes □ No □ | Fax # or E-mail Address |
| **Reentry Accountability Plan:** |
| My self-defeating behavior that blocks my success with this issue:  |
| My behavioral goal to address my issue is:  |
| My action plan to meet the above goal: | Target Completion Date: | Completion Date: |
| Staff action plan to meet the above goal: |
| Comments: |
|  |
| **2. Referral Type:** |
| In-Custody: □ | At Discharge: □ | Post-Release: □ |
| Agency Referred To:  | Contact Phone: | Contact Person: |
| Appointment Date/Time: | Location: | Referral Faxed/E-mailed: Yes □ No □ | Fax # or E-mail Address |
| **Reentry Accountability Plan:** |
| My self-defeating behavior/problem that block my success with this issue:  |
| My behavioral goal to address my problem is: |
| My action plan to meet the above goal: | Target Completion Date: | Completion Date: |
| Staff action plan to meet the above goal: |
| Comments: |
|  |
| **3. Referral Type:** |
| In-Custody: □ | At Discharge: □ | Post-Release: □ |
| Agency Referred To: | Contact Phone: | Contact Person: |
| Appointment Date/Time: | Location: | Referral Faxed/E-mailed: Yes □ No □ | Fax # or E-mail Address |
| **Reentry Accountability Plan:** |
| My self-defeating behavior/problem that blocks my success with this issue:  |
| My behavioral goal to address my problem is: |
| My action plan to meet the above goal: | Target Completion Date: | Completion Date: |
| Staff action plan to meet the above goal: |
| Comments: |
|  |
| **4. Referral Type:** |
| In-Custody: □ | At Discharge: □ | Post-Release: □ |
| Agency Referred To: | Contact Phone: | Contact Person: |
| Appointment Date/Time: | Location: | Referral Faxed/E-mailed: Yes □ No □ | Fax # or E-mail Address |
| **Reentry Accountability Plan:** |
| My self-defeating behavior/problem that blocks my success with this issue:  |
| My behavioral goal to address my problem is: |
| My action plan to meet the above goal: | Target Completion Date: | Completion Date: |
| Staff action plan to meet the above goal: |
| Comments: |
| **Completion of Plan** |
| Full plan completed and discussed with inmate?  | Yes □ | No □ |
| If no, why? | Inmate refused □ | Court release before plan completed □ | Incomplete for other reasons □ | Specify: |
| **Case Manager/Counselor Information** |
| Name of Case Manager/Counselor: |
| Facility: | Inmate Housing Area: |
| Date Memorandum of Agreement Signed: | Date Discharge Plan Completed: |
| Case Manager/Counselor (signature): | Phone #: |
| Supervisor: | Phone #:E-mail Address: |
| **Inmate Agreement** |
| I have participated in the completion of this transition plan, received a copy of this transition plan, emergency numbers for assistance in the community, and necessary psychiatric referrals (if necessary).  |
| Inmate’s Name: |
| Inmate’s Signature: | Date: |